BUILDING ADAPTIVE NURSE LEADERS FOR FUTURE ARMY FULL SPECTRUM OPERATIONS.

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by

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Fifteen interviews were conducted of senior Army Nurse Corps officers to find common themes on what specific aspect of education and developmental experiences need to be incorporated into the Army Nurse Corps lifecycle model. Purposive sampling was used to ensure a sample population with a variety of experiences to include deployments, recruiting, command and joint operational assignments. Results indicated major themes in areas of improvement such as military education, field experience, renewed focus of medical surgical bedside nurse care for junior officers and the need to create two tracks for the life cycle model to ensure equal opportunity of advancement for both expert clinicians and administrative leaders.

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The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.).

ABSTRACT

BUILDING ADAPTIVE NURSE LEADERS FOR FUTURE ARMY FULL SPECTRUM OPERATIONS, by MAJ Tamara Susan Funari, 96 pages.

The Army Nurse Corps life cycle model outlines major milestones that are required, expected, or recommended to be achieved for career success and to prepare Army Nurses to become senior leaders in the Army Medical Department. It is important to ensure Army nurses will be prepared to function in the uncertain current and future full spectrum operational environment. The purpose of this thesis was to examine the Army Nurse Corps Life Cycle Model and avenues within the model to determine specific aspects of education and developmental experiences that will assist in developing Army Nurse Corps officers to become adaptive senior nurse leaders.

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ACRONYMS

AMEDD	Army Medical Department
AMEDDC&S	Army Medical Department Center and School
ANC	Army Nurse Corps
Bde	Brigade
BG	Brigadier General
BOLC	Basic Officer Leadership Course
CCC	Captain's Career Course
CPT	Captain
COL	Colonel
CSH	Combat Support Hospital
CSL	Centralized Selection List
CGSC	Command and General Staff College
CN	Chief Nurse
CNS	Clinical Nurse Specialist
CNL	Clinical Nurse Leader
CV	Curriculum Vitae
DCN	Deputy Commander of Nursing
DGDP	Director of Graduate Degree Programs
GDP	Graduate Degree Programs
FSO	Full Spectrum Operations
GDP	Graduate Degree Program
GWOT	Global War on Terror
HN	Head Nurse

ILE	Intermediate Level Education
KD	Key and Developmental
LT	Lieutenant
LTC	Lieutenant Colonel
MG	Major General
MAJ	Major
MILPER	Military Personnel Message
MMAS	Masters of Military Arts and Science
MRMC	Medical Research and Material Command
MS	Medical Service
MTF	Medical Treatment Facility
OBC	Officer Basic Course
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PROFIS	Professional Officer Filler Information System
SAMS	School for Advanced Military Studies
TDA	Table of Distribution and Allowance
USAREC	United States Army Recruiting Command

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CHAPTER 1

INTRODUCTION

Purpose

This thesis examines the Army Nurse Corps (ANC) Lifecycle Model comparing the education and experience pathways of Army Nurse Corps Officers with other branches of the Army in the focus area of leadership. This thesis also compares the needs of the ANC with the needs of the Army in the area of building adaptive leaders by reviewing the current and predicted future operational environments. The purpose of this thesis is to determine what changes, if any, the Army should make to the Army Nurse Corps lifecycle model in order to "build the bench"[1] with future adaptive nurse leaders.

Background

The ANC life cycle model, as shown in figure 1. outlines major milestones for Army Nurses to achieve for career success and to prepare for future leadership positions. Some of the career milestones in the ANC life cycle model are intended to correlate directly with the other branches of the Army. For example, leadership assignments such as head nurse for the ANC are meant to parallel key and developmental (KD) assignments such as company commander for the non-clinical branches. With the dramatic changes of the Army's operational concept from conventional warfare to full spectrum operations which includes both counter insurgency operations and joint operations these general correlations may no longer apply. The military education and experience pathways are completely different for nurses than for non-nurse corps branches. Yet at the senior level, nurses are expected to have the same military

knowledge in addition to clinical knowledge expertise. Some of these variants will be discussed in greater detail throughout this thesis.

This topic is of particular interest to the current Chief of the ANC, Major General (MG) Patricia Horoho, who announced in the September 2008 edition of the *Army Nurse Corps Newsletter*, the new campaign priorities that she plans to achieve during her tenure. MG Horoho's very first priority is, "Leader Development, Building Our Bench."[2] The focus of this priority is educating and mentoring nurse corps officers to become adaptive nurse leaders who are able to effectively respond to the Army's and the patients' needs. See figure 1. below.

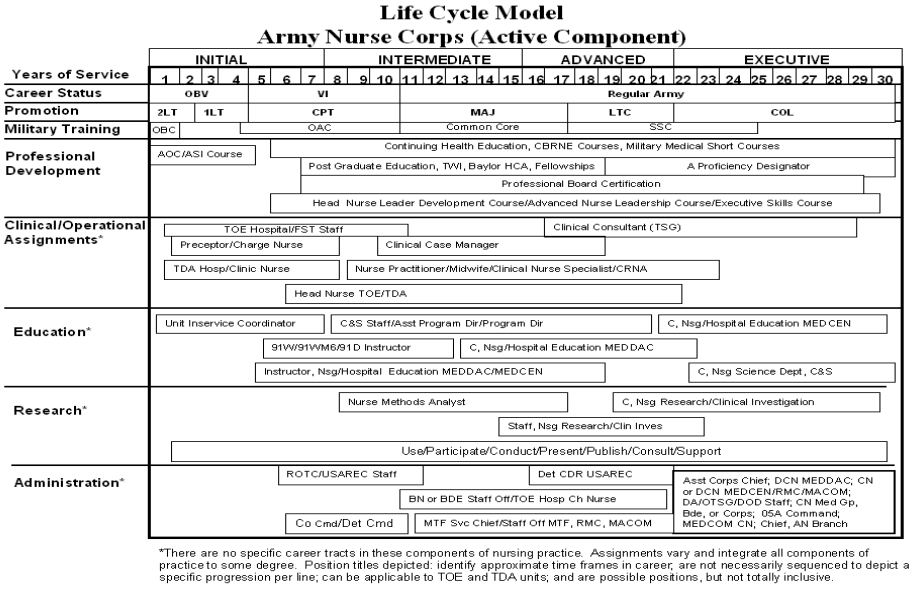

Figure 1. Army Nurse Corps Lifecycle
Source: "Army Nurse Corps," *Branch Orientation*, http://www.branchorientation.com/nurse/education_pgs/lifemodel_img.html (accessed 23 September 2008).

Currently, the Army Medical Department (AMEDD) is undergoing a transformation into modular combat support hospitals which are intended to be more mobile and capable of split based operations increasing the ability to effectively operate in full spectrum operations. The term full spectrum operations (FSO) refers to the Army's doctrinal operational concept which explains how each mission and the environment surrounding the mission determines the relative effort of the four elements offense, defense, stability, and civil support.[3] Based on the expected operation, leaders of the AMEDD in that theater of operations must strategically plan their mission to support the main effort. Figure 2 depicts the anticipated contribution of each type of operation based on the mission. For example, at the start of Operation Iraqi Freedom the mission of the U. S. Forces was primarily offensive in nature. During offensive operations there will be a large amount of defensive maneuvers being conducted as well. Because offensive and defensive maneuvers cause casualties and damage to surrounding infrastructure, stability operations cannot be the primary objective. Security is a major objective and the area of operations must be secure in order for stability or civil support operations to be conducted. Since the area is secured prior to conducting major stability operations, the offensive and defensive mission is decreased. There will be some offensive and defensive operations conducted to ensure security is maintained but they will not be the main effort. The units conducting stability operations become the main effort. The AMEDD has a significant role in all phases. Soldiers cannot conduct operations without the nurses and other medical personnel in place and ready to care for them. Figure 2 is a visualization of this balance.

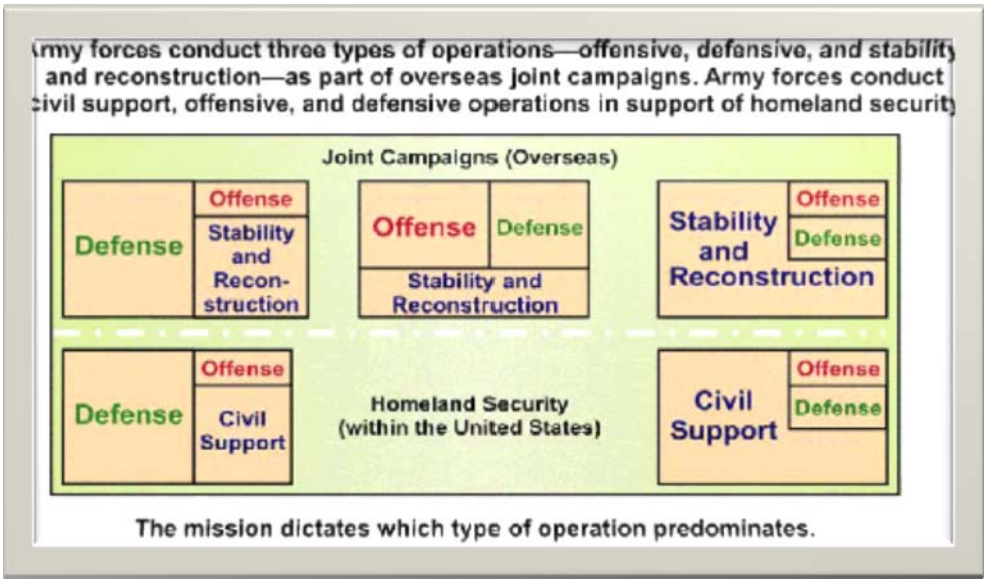

Figure 2. Full Spectrum Operations
Source: Headquarters, Department of the Army, Field Manual (FM) 1, *The Army* (Washington, DC: Government Printing Office, 2005), 3-6.

To meet the requirements to achieve the variety of missions encompassed by FSO, the Army has begun the most profound strategic transformation since World War II (1939-1945) and is currently updating doctrine to reflect this.[4] This transformation will enable the Army to strengthen capabilities across the force and improve its ability to lead in a joint operational environment. The Army transformation model is outlined in figure 3. The arrow at the top of the diagram depicts a flow from the current to the future force. The acronym DOTMLPF is displayed at the right with the components Doctrine, Organization, Training, Material, Leadership and education, Personnel, and Facilities. These components are areas of concern for Army leaders to assess, utilize, and improve as stepping stones to enhancing the capabilities of the Army to be able to fully support

the future Joint Force. A Joint Force is the combination of two or more U.S. Military Services working together.[5]

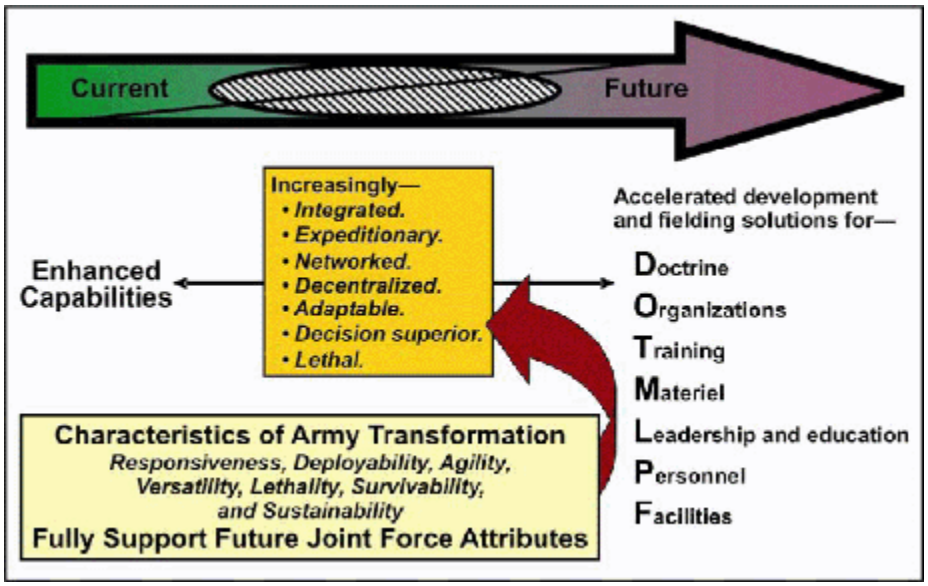

Figure 3. Army Transformation Model 1
Source: Headquarters, Department of the Army, Field Manual (FM) 1, *The Army* (Washington, DC: Government Printing Office, 2005), 4-3.

Because of the nature of FSO and the Army's transformation to meet the changing environment, Army Nurses should expect to find themselves in branch immaterial or joint operation assignments and in environments dramatically different from their civilian counterparts. In order to provide quality patient care and to perform in these environments Army Nurses must be intuitive, flexible, competent, and adaptable to enhance their ability to be effective in these dynamic and uncertain conditions. Senior Army Nurse Leaders must be able to contribute to joint operational planning and potentially take command of complex units with diverse missions. Just as leaders within other branches of the Army must invest in increasing their capabilities to build adaptive

leaders by constantly assessing doctrine, training, and organizational experiences, the Army Nurse Corps must assess its doctrine, training and career pathways to achieve its goal "Building our Bench"[6] with highly skilled, critical thinking, and adaptive nurse leaders.

The author of this thesis examined the various layers of leadership in the Army Medical Department and Army Nurse Corps. Education and developmental experiences Army Nurses receive were explored in order to provide recommendations that may be incorporated into the ANC lifecycle model in order to build Army Nurse Corps Officers for the uncertainty of future operations.

Primary Research Question

How can the Army Nurse Corps develop adaptive nurse leaders who will be prepared for current and future operational environments?

Secondary Research Questions

1. What does the term "adaptive" nurse leader mean?
2. What are the components of the doctrinal ANC lifecycle model?
3. What type of leadership competencies and capabilities are needed to meet the current needs of the military and our patients?
4. What are the needs of the AMEDD and the ANC in relation to the Army today?
5. What are the similarities and differences of leadership education between the ANC and other branches of the AMEDD?
6. What education is most important in developing nurse leaders?

7. What experiences are most important in developing nurse leaders?

Significance

Army Nurse Corps officers must be adaptive leaders who are able to provide quality nursing care and effectively lead in any operational environment. If the data found in this descriptive study shows that the Army Nurse Corps life cycle model is not fulfilling the requirements needed for well-rounded, adaptive nurses then additional experiences and education opportunities need to be incorporated. Additionally, data collected in defining characteristics and competencies of adaptive nurse leaders could be integrated into tools used for evaluating overall leadership abilities prior for selection for leadership positions.

Assumptions

1. Adaptive nurse leaders are needed to ensure the ANC can meet the future needs of the Army.

2. Full spectrum operations have dramatically increased in the last 20 years and will continue to increase, causing a shift in responsibilities Army Nurses are being asked to assume.

3. The Army is transforming the force to increase capabilities for supporting the future Joint Force. The ANC will need to compliment this transformation by assessing and incorporating change to components of DOTMLPF also which will directly affect the type of responsibilities required for ANC officers.

Definitions

Adaptability. Ability to effectively change behavior in response to an altered environment or situation.

Army leader. As defined by Field Manual (FM) 6-22, "anyone who by virtue of assumed role or assigned responsibility inspires and influences people to accomplish organizational goals. Army leaders motivate people both inside and outside the chain of command to pursue actions, focus thinking, and shape decisions for the greater good of the organization."[7]

Adaptive leader. A leader who has the ability to influence people by providing purpose, direction, and motivation while operating in a complex, dynamic environment of uncertainty and ambiguity to accomplish the mission and improve the organization. An adaptive leader is able to change behavior and leadership style as needed to meet the needs of the organization due to a change in mission, situation, or audience.

Level I and II command boards. Centralized selection boards for command are divided by the size of the organization or medical center. Level II is equal to a brigade size element or a large medical center such as Walter Reed Army Medical Center. Level I is a smaller unit such as a combat support hospital.

Scope and Limitations

The author examined Army doctrine, Joint doctrine, and research to discover the needs of the Army in relation to leadership and how this impacts the desired competencies and capabilities needed of the Army Nurse Corps.

The major limitation in conducting this research was allowing time to collect and analyze data and write the thesis given the competing demands of the Command and

General Staff College. This study was done in only nine months of part-time work. Also, locating and interviewing senior ANC leaders who have held various challenging and unconventional positions was a challenge. This thesis was limited to only U.S. Army Nurses.

Delimitations

Interviews were focused to narrow information collected to leadership competencies and not on other competencies required of nurses such as clinical, research, or patient care. The author excluded all nurses below the rank of lieutenant colonel because officers with the rank of major and below normally do not have a broad assignment history. The thesis did not include civilian nurses, Navy or Air Force nurses.

Summary

The purpose of this chapter was to introduce the reader to the ANC life cycle and to provide a brief view of how the ANC develops nurses that are successful Army officers as well as clinical experts. Army Doctrine in the terms of understanding full spectrum operations and the Army transformational model was explained. The intent was to provide a basis of understanding of how the ANC fits into Army organizations. Additionally the author introduced scope and limitations to this project, as well as delimitations. My research and theory building on the secondary research questions will be discussed in chapter 2 in an attempt to determine a possible solution to the primary research question; How can the ANC develop adaptive nurse leaders who will be prepared for current and future operational environments?

[1]Major General Patricia Horoho, "Our Priorities," *The Army Nurse Corps* 8, no. 7 (September 2008): 1, http://www.us.army.mil/suite/portal/index.jsp (accessed September 20, 2008).

[2]Ibid. 1.

[3]Headquarters Department of the Army, Field Manual (FM) 3-0, *Operation.* (Washington, DC: Government Printing Office, 2008), 3-1.

[4]U.S. Army Training, and Doctrine Command, Field Manual (FM) 1, *The Army* (Washington, DC: Government Printing Office, 2008), 4-1 to 4-13.

[5]Joint Chiefs of Staff, Joint Publication (JP) 1 (Washington, DC: Government Printing Office, 2007), I-2.

[6]Horoho. 1.

[7]Headquarters Department of the Army, Field Manual 22-100, *Army Leadership: Competent, Confident, and Agile* (Washington, DC: Government Printing Office, 2007), 1-1.

CHAPTER 2

LITERATURE REVIEW

The role of leadership is to turn challenges into opportunities[1]

General Dennis J. Reimer, Chief of Staff, Army

The purpose of this thesis is to investigate the question: how can the Army Nurse Corps (ANC) develop adaptive nurse leaders who will be prepared for current and future operational environments? In answering the primary research question, the author also hopes to determine what changes, if any, the Army should make to the Army Nurse Corps life cycle model that will assist with promoting the campaign pillar, "build the bench"[2] with future adaptive nurse leaders. The purpose of this chapter is to explore the major sources of literature that illustrate how this information is important to answering the primary research question.

First, a historical summary of past leadership roles of Army Nurses will be provided leading to the events which expanded the roles of the ANC from traditional nursing roles to significant leadership positions such as Commander and Joint Operations Planner. The chapter is then organized by secondary research questions beginning with the most basic but necessary question: what does adaptive leadership mean? Other areas of discussion are: What is the purpose and content of the ANC lifecycle model and how does it apply to future operations? What leadership competencies and capabilities are needed in the ANC? How does ANC leadership education compare with that of other branches of the Army Medical Department (AMEDD)? What education and experiences are needed to develop adaptive nurse leaders?

Historical Accounts

Army Nurses have been expanding their roles since the establishment of the formal existence of the Corps on 2 February 1901. The evolution of Army Nurses' roles and responsibilities are described by COL (Ret.) Mary T. Sarnecky in her book *A History of the Army Nurse Corps*.[3] Sarnecky provided detailed accounts of the nurses' role in the Army dating as far back as 1775. The initial nursing responsibilities were very basic, consisting of fundamental nursing activities such as feeding and bathing.[4] Sarnecky described the role of the Matron who was responsible for managing the other nurses on the wards. Nurses were subordinate to surgeons and ward masters and held the lowest position in the Army which was certainly reflected in their pay.[5]

About a year after the introduction of the Army Nurse Corps (ANC), as a formal officer corps, the role of the hospital Chief Nurse was officially developed and recognized as a position of leadership.[6] Sarnecky outlined the criteria for selection, "ability to govern, the most heavily weighted criterion; adaptability to Army work; practical nursing and executive experience."[7] In her book, Sarnecky provided detailed examples of how, as the Army transitioned through conflicts, wars, and natural disasters, the leadership roles for Army Nurses also expanded. However, it was not until 7 April 1947 that Congress finally passed the Army-Navy Nurses Act which officially acknowledged nurses as leaders by awarding them a permanent commission into the regular Army and Navy with all the same pay, benefits, and status as other Army officers.[8]

Lisa Budreau and Army Nurse Corps Officer, Lieutenant Colonel Richard Prior published historical documents and memoirs from Army Nurses who served in World

War I from 1917-1919. Budreau and Prior noted that the position of Chief Nurse, which came about because of necessity, was one of promotion not appointment. Nurses selected by the Surgeon General after being recommended by the Superintendent of the ANC, now known as Chief of the ANC, were promoted from the rank of nurse to the rank of Chief Nurse. [9] At that time, neither the Chief Nurse nor the Superintendent of nurses held any official officer rank. Their rank was their title nurse, Chief Nurse or Superintendent.[10] The ANC expanded greatly during World War I to provide the care needed for the sick and wounded soldiers. This expansion increased the need for additional organized leadership in the corps. Out of necessity came the position of Chief Nurse.[11] These facts illustrate the expansion of roles, titles, and positions Army nurses filled due to the needs of the Army. Additionally, it wasn't until 1920 when the first nurse received the rank of major. That was Julia C. Stimson, who was already in the position of Superintendent of the Army Nurse Corps when she received her rank.[12]

Judith A. Bellafaire wrote a historical summary of the contributions of Army Nurses during WWII (1939-1945). In her summary, she highlighted nurses' resilience while held as prisoners of war as well as their ingenuity in providing patient care in the most austere conditions with extremely limited supplies.[13] Bellafaire stated that nurses had to be adaptable leaders during WWII because they frequently took charge of the medical mission while providing care to an enormous number of wounded on the front lines. These nurses were forced to assume command responsibilities for care normally handled by physicians.[14] These and other experiences increased the ANC status and esteem across the Army. Nurses were encouraged by these experiences to seek out additional educational opportunities to enhance their clinical and leadership capabilities.

After nearly a century of proving their leadership potential and competency, ANC leaders were afforded the opportunity to compete for command of Army clinics and hospitals. General Alcide M. LaNoue was the Surgeon General of the Army from September 1992 to September 1996.[15] He was the Surgeon General presiding over the decision to expand opportunities for command for all AMEDD branches by instituting branch immaterial positions. The Army Medical Department held its first Branch Immaterial Command Board in October 1996.[16] Currently the positions filled at the Branch Immaterial Command Central Selection Board, a Department of the Army Secretariat Board, are listed below. Candidates selected are placed on a Centralized Selection List (CSL).

Medical brigades - level II Brigade, Level 1 combat support hospital, (CSH)

Strategic support - level II medical center/large medical treatment facility, (MTF), Level I MTF.

Scientific and technical - most are Veterinarian or Medical Service (MS) specialties for Medical Research and Material Command.

Training - AMEDD C&S.

Recruiting - United States Army Recruiting Command, USAREC.

Installation - currently MS only for garrison command and logistics.

The AMEDD recognizes other command positions, called Non CSL positions. In the past commanders selected officers through a nominative process, but in 2007 the AMEDD moved the MTF/Health Clinic Commands to an informal Non CSL board process for branch immaterial AMEDD officers. [17] Non CSL categories include:

Small MTF/Health Clinics

Troop Command (currently MS only)

ANC officers have been competing for branch immaterial commands for several years. The first ANC officer selected to command a military instillation was Brigadier General Clara Adams-Ender. She took command of Fort Belvoir in 1991. During that time, she also served as Deputy Commanding General for the U. S. Army Military District of Washington.[18] The first Army Nurse to command a medical center was MG Nancy R. Adams. She assumed command of William Beaumont Army Medical Center in November, 1995 and then in April 1998 she assumed command of Tripler Army Medical Center and the Pacific Regional Medical Command.[19] MG Adams was also the first Army Nurse to be nominated by the President for promotion to major general.[20] Another turning point in military history is the appointment of Brigadier General William T. Bester on 1 May 2000 becoming the first male Chief of the ANC.[21]

The ANC currently has one general, MG Patricia Horoho, the Chief of the ANC. In a telephonic interview with the Chief, Army Nurse Corps Branch, Human Resource Branch, on 13 February 2009, COL Suzan Williams expressed that Army Nurse Corps officers compete very well for both CSL and Non-CSL commands. She also stated that currently Army Nurses hold nine CSL commands with four more entering command this year. Two ANC officers were selected in the Fiscal Year 2009 Non-CSL command board.[22] In addition to the COL and LTC commands, the AMEDD also has CPT and MAJ commands. At the rank of captain, a nurse may compete for one of 10 company command positions.[23] Majors may compete for Forward Surgical Team commands. These positions are not boarded, however Human Resource Command normally provides

nominees to the senior commander review and selection. COL Williams explained the CSL and non-CSL board process during the telephonic interview to the author. Explanation is paraphrased below.

> CSL and non-CSL boards are held once a year. The formal, Department of the Army Secretariat holds two CSL boards per year, one for COL command (Bde command equivalent), and the other for LTC command (battalion command equivalent). The COL Command board has six categories, and include Medical Brigades (level II Bde, level 1 CSH), Strategic Support (level II Medical Center/large MTF, level I MTF), Scientific and Technical (most are Veterinarian or MS specialties for MRMC), Training (AMEDD C&S), Recruiting (USAREC), and Installation (currently MS only for Garrison Command and Logistics) The LTC board has two categories, Training and Recruiting. The non CSL are normally for Health Clinic MTF's and include LTC as well as COL commands. Officers may compete for command, but must meet criteria defined in each board military personnel (MILPER) message that is released about three months prior to each board.[24]

Adaptive Leadership

Army doctrine is a method that U.S. Army experts in various fields use to communicate to all Soldiers guidance for an immense variety of situations. Doctrine is developed from evidence-based practice, lessons learned, and theory. It is meant to be used as a tool for communication among the branches and "to foster initiative and creative thinking."[25]

Adaptable leadership is stressed in Army doctrine as an essential characteristic for Army leaders to possess in order to be successful in the current operational environment. Army doctrine states that leaders must be able to assess their environment, focus on key aspects and have the ability to change, adapt their behavior and influence the behaviors of their subordinates to assist with the organization's adjustment to a constantly changing environment. Doctrine states that adaptive leaders are change agents.[26] Ambiguous situations are seen as opportunities to an adaptive leader, not as problems.

Ronald Heifetz in his book *Leadership Without Easy Answers* (1994) provides an analogy of adaptive problems in relation to leadership and authority. Heifetz, founder of the Center of Public Leadership at Harvard University, refers to adaptive work as a leadership strategy that includes reality testing, negotiation, conflict resolution and developing organizational norms.[27] These are all challenges in sustaining excellence. Leaders should possess the ability to solve complex problems and turn these challenges into opportunities. Part of this task is developing a learning organization and using negotiation talents to resolve organizational conflicts. Basically, Heifetz's message is that adaptive leaders do not just cope with the situation at hand but they make the situation better in spite of ambiguity and change.

The National College for School Leadership published a literary review of Heifetz's follow on article *The Work of Leadership* (1997), which he wrote in collaboration with Donald Laurie. This article elaborates further on adaptive work in the context of leadership. One of their main points on explaining adaptive leadership is, "The leader must be emotionally capable to withstand uncertainty, frustration, and anxiety in order to communicate confidence."[28]

The previous two articles do not reference or apply the principles to nursing or the armed forces, however, the main themes of adaptive leadership as discussed in these studies are applicable. Army Nurse Corps officers need to communicate confidence to their subordinates, peers and especially patients. This is an incredibly valuable trait to have during a mass casualty situation or in austere environments when traditional methods are not feasible. Adaptive nurse leaders holistically view the context for change and see this as an opportunity for challenge and organizational or system improvement.

Another theory described adaptive leadership as a "dynamic process of mutual influence."[29] Dr. Charles Albano (2007) addressed adaptive leadership by comparing it to mechanical systems. He explained that adaptive leadership is a very active type of leadership in which leaders actively seek out opportunities to impact the environment. This is in stark contrast to mechanical leaders, who basically react to the change that is happening around them. In his article he compared views between mechanical and adaptive leadership. Adaptive leaders allow for flexibility; they focus their attention on outcomes not the method. Adaptive leaders are able to flow from one role to another; they exhibit a "can do" attitude and encourage others to do the same.[30] This view of adaptive leadership is one of excitement, empowerment and ingenuity.

Dr. Stephen Byrum (2008) described adaptive leadership in a different light. He compared definitive work with adaptive work, highlighting on the basic concept that definitive work is the articulated steps of accomplishing a task and achieving results. Adaptive work as he defined it is "the highest order of leadership required."[31] Dr. Byrum described adaptive leaders as creators with powerful vision and intent. Failure is not an option for these leaders as they are driven by courage, conviction and faith.[32] His theory of adaptive leadership is based on a spiritual dimension but developed from his 30 years of experience as a leadership professor and consultant at the University of Tennessee.

The previous three theories of adaptive leadership were from a civilian perspective looking at the general concept of leadership. So, how do military leaders theorize adaptive leadership? MAJ John Burpo addressed adaptive leadership in his article, "The Great Captains of Chaos" (2006). In this article he lists traits of the adaptive leader:

1. Be decisive

2. Balance human leadership dimensions with technology

3. Be comfortable with uncertainty

4. Be a focused, quick learner.

5. Be able to empower and decentralize leadership, allowing for initiative within intent.

6. Be a good communicator.

7. Build cohesive, trusting teams with candor.

8. Use force across the full spectrum of conflict.[33]

Burpo clearly articulates various definitions of leadership and adaptive leadership as he interprets it from his study of Army doctrine. He took a narrow approach to these views translating what he believes Army doctrine states in field manual 22-100. Burpo stated that Army doctrine instructs leaders that they must be able to operate in ambiguous environments but doesn't explain how this is to be done. Burpo did conclude from his research that adaptive leaders have the ability to cultivate change, are creators and innovators, and are willing to accept unpredictability.[34]

Dr. Lenard Wong conducted a study of adaptive leadership by analyzing monographs collected from soldiers who deployed to Operation Iraqi Freedom in 2004. In his study, Wong describes adaptive leaders as having the ability to identify and respond to change intelligently and quickly.[35] Out of necessity, junior officers are rapidly developing this skill on the battlefield.

Army Nurse Corps Life Cycle Model

The ANC life cycle model is a tool used by all Army Nurses and their branch managers to gauge the education and experiences they should receive at specific points in their career. Some milestones, such as attending the Captains Career Course, are non-negotiable if the officer aspires to the rank of Major. Other milestones are simply guidelines depending on what career path the officer wants to take whether it is that of remaining clinical or moving into the administration realm. However, most ANC officers take on more of an administrative or leadership role by the time they reach Lieutenant Colonel. Leadership is not specifically represented in the model. The author found the life cycle model on the ANC branch website, refer to chapter 1, figure 1, however, literature to support this model could not be located. The author could not find historical data or evidence based research supporting the use of the model or its advantage in preparing ANC officers for senior leadership positions.

Leadership Competencies and Capabilities Required of Army Nurses.

The Chief of Staff of the U.S. Army General George Casey delivered the keynote address at the Association of the United States Army (AUSA) luncheon in October 2008. He stressed the importance of developing adaptive leaders who can be successful in contending with the challenges of full spectrum operations.[36] He articulated the competencies he believes are important for the Army's current and future leaders to possess:

> Our leaders in the 21st century must be: supremely competent in their core proficiencies; broad enough to operate across the spectrum of conflict; able to operate in joint, interagency, and multinational environments; at home and in other cultures; and, most importantly, they have to be grounded in our Values and our Warrior Ethos.[37]

As stated previously in this chapter, the ANC prides itself on developing the clinical core competencies of the ANC officers. The question remains: Does the ANC develop the leadership competencies adequately to ensure adaptive nurses are leading the Army's healthcare program both in the deployed and garrison environments? Do Army nurses possess all the skills emphasized by GEN Casey?

Just as Army Nurse's roles and positions have expanded, the competencies and capabilities that an Army Nurse must possess have also increased. The first and foremost competency required of an Army Nurse is that of clinical excellence.[38] Major General Gale Pollock who recently completed her term as Chief of the Army Nurse Corps (2004-2008) stressed this focus in the Army Medical Department Journal. She illustrates that clinical practice, education, research, and leadership are all areas in which Army Nurses strive for excellence. The ANC achieves clinical excellence by providing a thorough preceptorship at the start of a nurse's career followed by a year of staff nursing with emphasis on lieutenants acquiring medical surgical experience. Then a specialty course is offered in a variety of areas such as intensive care, operating room nursing, and maternal--child nursing. The ANC also provides scholarships for graduate school allowing nurses the opportunity to compete for a full scholarship to their school of choice. In addition to this formal education, every Army Healthcare Center and hospital offers free continuing education from one hour courses to week long conferences. Finally, for senior level nurses the opportunity also exists to compete for a doctorate level education scholarship. With all the opportunities to grow in clinical skills the question still remains, what kind of leadership competencies and capabilities do Army Nurses need and how does the Army Nurse Corps go about achieving those goals? Several

formal leadership courses currently exist for nurses such as pre-command course, legal orientation course for newly selected commanders, and various leadership courses offered through Army Medical Department.

Dr. Mi Ja Kim (2005) stated that nurses need to develop a global mindset to keep up with the globalization phenomenon.[39] She articulates Heifetz's definition of adaptive leadership, saying that these leaders separate the old historic practices from the way things need to be done to correlate with current values. Adaptive nurse leaders "view patterns of nursing behaviors from the balcony."[40] Nurses need to be able to look at the organization, patients, healthcare and clinical scenarios globally and holistically and create the circumstances to enable change while protecting their organization from feeling the stress and external pressures that sometimes accompany change. Kim explained that a competency nurses need to cultivate is the global mindset in order to become global leaders. In her theory on effective nurse leadership she incorporated the globalization phenomenon with Heifetz's theory of adaptive leadership and provides clear competency requirements nurses need to possess to become effective leaders. Competencies required of effective leaders are: cultural competence, open-mindedness, flexibility, resiliency, and resourcefulness. They must also be optimistic and have the capability to deal with a cognitive picture and incorporate all parts of the puzzle in any given scenario to select the best course of action to solve the problem and achieve the most optimal results.[41] Figure 4 is a concept model the author created to illustrate Kim's work.

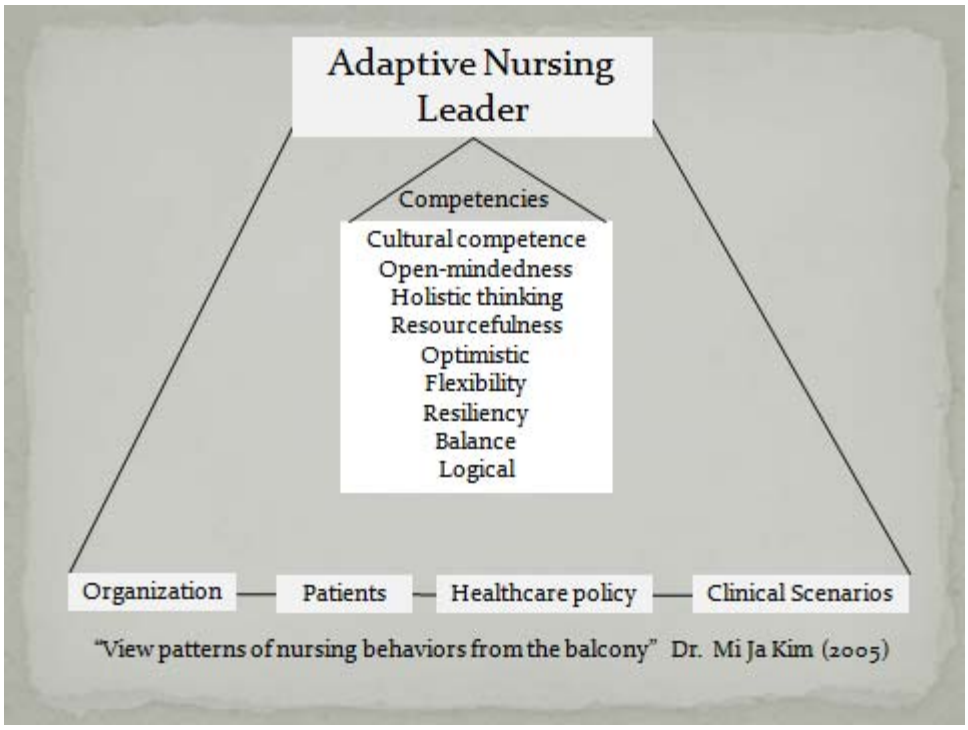

Figure 4. Adaptive Nursing Leader
Source: Mi Ja Kim, "Developing a Global Mindset for Nursing Scholarship and Health Policy," *Australian Journal of Advanced Nursing* 22, no. 3 (2005).

Kim stressed the importance of having the ability to balance emotionally complex nursing with business. Nurses often become emotionally wrapped up in how their perspective unit conducts daily activities and their routine. There is a culture within nursing especially among nurses who have been practicing for many years. Effective leaders can logically assess the business of nursing and health care and can find better ways of improving patient care and providing the best care to the most patients. Nurses that have mastered the ability to promote interventions which will improve the business of nursing together without upsetting the dynamics of the organization so much as to cause conflict within the nursing culture, have mastered the art of balance. Truly great leaders have this ability.

Kim's theory of adaptive leadership compliments the Army's doctrine regarding leadership. FM 6-22 illustrates eight core leadership competencies. Figure 4. displays the Army core competencies and supporting behaviors required of Army leaders. This model does not directly speak to adaptive leadership but characteristics of adaptive leaders are implied. These implications are in the descriptions of four of the competencies. These descriptions are "lead with confidence in adverse conditions, set conditions for a positive climate, be prepared for unexpected challenges, and develop on the job."[42] The eighth competency is "gets results."[43] Leaders must be adaptive in order to build these competencies and incorporate all of them simultaneously in their leadership philosophy.

FM 6-22 does directly discuss adaptability as an important component to becoming a successful leader. In this doctrine, adaptive leaders are described as being able to scan the environment focusing on key aspects of every situation with the ability to alter the situation to meet the mission.[44] Army doctrine speaks to the other characteristics which were also highlighted in Kim's article, such as cultural awareness, flexibility, resourcefulness and resiliency throughout FM 6-22.

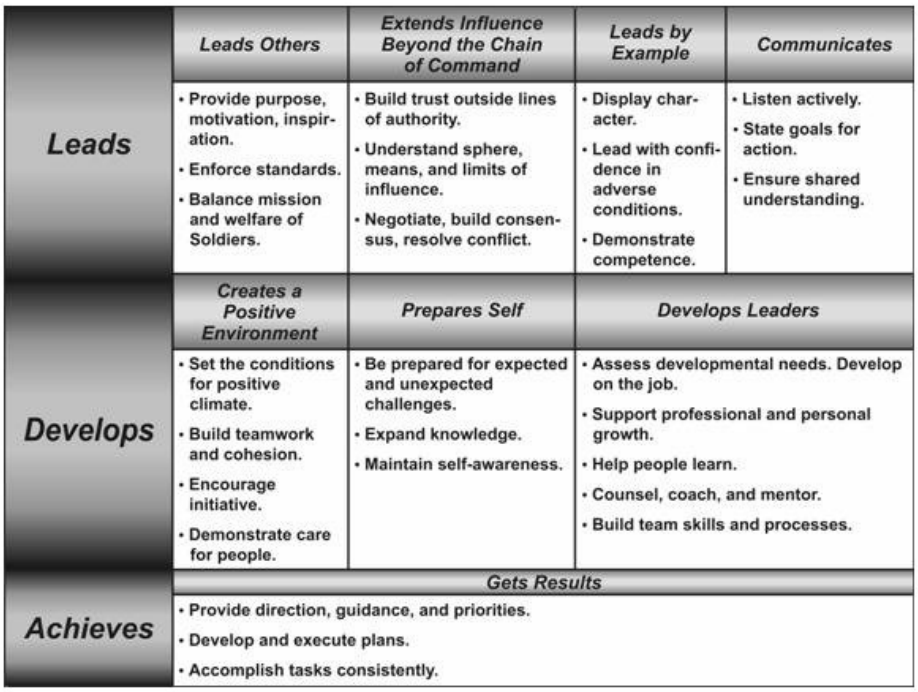

Figure 5. Army Core Competencies
Source: Headquarters, Department of the Army, Field Manual (FM) 6-22, *Army Leadership* (Washington, DC: Government Printing Office, 2006), 2-7.

Army Nurse Corps Leadership Education
Comparison with other Army branches

In this literature review the author found that many theories of adaptive leadership and developing the competencies and capabilities of nurse leaders refer to Heifetz as a guide. The National Public Health Leadership Institute uses works by Ron Heifetz and Wilfred Drath to guide its thinking and curriculum.[45] Two of Heifetz's books, *Leadership Without Easy Answers* and *Leadership on the Line*, are also required reading at the School of Advanced Military Studies, (SAMS). SAMS is a continuation of the Command and General Staff College (CGSC) at Fort Leavenworth, Kansas which develops mid-level officers to become successful military commanders and leaders. The SAMS missions statement states:

> The School of Advanced Military Studies educates the future commanders and leaders of our Armed Forces, our Allies, and the Inter-agency at the graduate level to be agile and adaptive leaders who think critically at the strategic and operational levels to solve complex ambiguous problems.[46]

The students at SAMS come primarily from a combined arms background but a few Army Medical Service Corps Officers have attended, as well**.** ANC officers are not eligible to apply.

LTC Carlen Chestang Jr. conducted a strategic research project, in 2006 examining how the Army Officer Corps adapted with the changing of the times. Within the context of his study he looked at the military education Army officers receive to provide them with the tools needed to be successful in joint, interagency, and multinational environments while conducting full spectrum operations.[47] Chestang began his study by taking a historical look at how the Army developed the officer corps from the 1940s to the present. His focus was primarily on how officers were selected and what was expected of them. Chestang introduced some of the political decisions on officer selection and assignments such as integration of African-American and female officers. He explained how these special groups would be expected to perform and how they would be compensated. Female officer restrictions were very specific in the 1940s, 50s, and 60s. Some of these restrictions as outlined by Chestang were "could not serve in combat, could not be promoted above lieutenant colonel, could not command men, and could not receive retirement benefits."[48]

It was not until 1972 that the Department of Defense authorized more leadership roles and allowed women to be promoted to the rank of Lieutenant Colonel.[49] This information is important because it sets the stage for future challenges in the development of all officers and especially nurse corps officers, who are primarily women. Other

groups, particularly minority groups, had similar restrictions to their career enhancement opportunities.

Chestang stated that it is important to understand change to ensure effective officer leaders. The historical summary above is important not because history repeats itself but because we need to know where we have been in order to continue to move forward. According to Chestang, the Army has continued to charge forward in response to challenges presented by the current FSO environment. In 1997, according to Chestang, General Dennis Reimer created a Study Task Force to ensure the development of Army Officers that will be effective in the changing environment. One of the requirements of the study group which is relevant to this thesis is, "To integrate concurrent leader development, character development, and turbulence reduction initiatives."[50] This author's interpretation of that requirement is that all Army officers should be equally educated and trained in the areas of leadership and character development.

Chestang illustrated the importance of this military education on officers' abilities to be prepared for full spectrum operations in these varied and changing environments. Chestang outlined the new Basic Officer Leadership Course (BOLC), which is a three-phase course, stating that all officers regardless of race or sex will attend and the course is designed not only to prepare officers for their first leadership assignments but also to identify officers who lack the potential to become capable leaders.[51] Other education courses mentioned in Chestang's paper are the officer advanced course for captains now titled the captains career course, combined arms staff course, and combined arms battle command course for company commanders. The combined arms staff course no longer

exists. At the field grade level, officers attend in-resident Intermediate Level Education (ILE). Chestang stated that ILE is intended to prepare mid-level officers for their next ten years of service and he also states that all mid-level officers will receive the same level of military education.[52] Lastly, he briefly described the final level of education for an officer, which is the Army War College intended to prepare senior officers for strategic level leadership.

After reading Chestang's thesis about how the Army is preparing the officer corps for the future, it became clear to the author that Chestang generalized his analysis to include all officers without mentioning the difference between the operational branches and the Army Medical Department (AMEDD). The author visited the AMEDD Center and School to research how similar or different AMEDD officer education was with the rest of the Army and specifically how the ANC's military education compared.

The AMEDD has a very different program for leadership education and preparation of its officers. The only AMEDD officers that attend a program designed to mirror the BOLC phases I, II, & III are two specialties within the Medical Service Corps and one in the Specialty Corps. The three phases of BOLC are outlined below:

Phase I--a general course that officers receive at their commissioning source, such as the military academy, or at the reserve officer training course at the college the officer attended.[53]

Phase II--is a six week common core training course which focuses on the seven Army values, military leadership, customs and courtesies and general military skills necessary to survive on the battlefield.[54]

Phase III--is a branch specific course and the length of each course varies, with the course contents being tailored to each specialty.[55]

The ANC does not attend these three courses. Some ANC officers might have the opportunity to attend BOLC if they were enrolled in ROTC in college. However, many ANC officers receive a direct military commission, which means that they apply for a commission as a registered nurse. Once selected, they raise their right hand, recite the oath of office and receive their commission. These officers then attend the Officer Basic Leader Course (OBLC) which consists of a seven week course where the officers learn common core skills some of which are included in the BOLC course phases I& II. The last two weeks of OBLC provide specific nursing information.[56] This entry level education for nurse corps officers is much shorter than that of other Army Branches.

The AMEDD Captains Career Course, which is taken prior to promotion to major, is mirrored by that of other Army Branches. The core curriculum is the same and is developed by the Center for Army Leadership.[57] After the common core is completed then the remaining elements of the course are branch specific.

The ANC Intermediate Level Education consists of the exact same books, exams and curriculum as other branches of the Army. The difference lies in the method of delivery for the material taught. All operations career field officers must attend the Command and General Staff College (CGSC) in residence for 10 months at Fort Leavenworth, Kansas. CGSC consists of Intermediate Level Education (ILE) common core curriculum followed by the Advanced Operations Warfighting Course. AMEDD branches are allotted a varied, but very small number of slots, to send officers that are selected by a competitive board to attend. The ANC receives extremely few slots,

usually one or two. The author is currently attending CGSC in residence as the only ANC officer in class 2009/01 which has a total of 960 students. According to the CGSC registrar the last year ANC officers attended the 10 month resident ILE was 2005.

The other alternatives that ANC officers may take to receive their ILE education is through the Reserve Component Training Integration which is part of the Total Army School System with a two week entry track followed by 13 months of one weekend a month classes, and concluding with a two week finalization course.[58] An in-resident, 16 week, ILE common core course is also available. This course mirrors the ILE portion of the resident CGSC course. The final method is through a correspondence course done completely on the officer's own time and self taught.

Although the curriculum is exactly the same the question remains: Is the education quality the same for in-resident students as it is for reserve program and distant learning students? This is a question that would be best answered with future research.

Education and Experiences Important for Developing Adaptive Nurse Leaders

As defined earlier, a characteristic of an adaptive leader is the ability to embrace change. Karlene Kerfoot expanded on this theory in 2004 by researching how to develop this characteristic. She wrote that leaders must continuously ask questions, to develop a cycle of learning.[59] Kerfoot explained that too often leaders just tell others what to do and frequently defend their actions when failures occur. She wrote that thinking and visualizing change and questioning methods, policies, and procedures to ensure quality improvement are the things that leaders should promote. Kerfoot stated that leaders who see challenges as opportunities instead of problems will be the most adaptable and

strongest leaders. They are leaders for which "Impossible thinking becomes a real possibility."[60] According to Kerfoot, implementing a continuous learning program will lead to an innovative and visionary organization.

Also, in the civilian nursing sector, the American Association of Colleges of Nursing (AACN) has forged the way for the clinical nurse leader (CNL) role. This is a specific area of focus for building nurse leaders in the civilian community. The Veterinarian Affairs (VA) has also embraced the CNL role. A joint conference sponsored by the AACN and the VA for clinical nurse leaders was held in New Orleans, Louisiana on 28 January 2009.[61] To become a CNL a nurse must obtain a masters degree with the CNL concentration which focuses on nursing leadership, clinical outcomes and environmental care management.[62] The theory, as reported in the Hunterdon case study, for the development of the CNL concentration is that healthcare organizations are complex and constantly changing so the nursing profession needs adaptive leaders who are flexible and capable to strategically turn issues into opportunities.[63]

A task force of senior executive nurses and professors of nursing collaborated on a project to design a new nursing leadership development model for nurses who are on the path to managerial and other leadership positions in the healthcare society. They reviewed results from various leadership studies such as a Magnet Hospital study and Voluntary Hospitals of America study on leadership and found a strong connection to hospital success and effective leadership.[64] Some common problem areas found in leadership education are that staff nurses are often placed in managerial positions before they are prepared and gaps between education preparation, and complex competencies required for success exist.[65] This is a civilian viewpoint, so multiply this environment

with a wartime scenario where nurses as inexperienced as second lieutenants are often placed in shift leadership positions in charge of extremely busy wards that receive combat wounded. These nurses all earn their degrees at civilian institutions and receive some leadership education. However this leadership education is far from what is required of Army officers.

Leadership Competence for the New Millennium was the title for the project to provide nursing students quality and active leadership education with a main objective to: "Establish competencies and content areas needed to prepare nurse leaders who will be high performers in a complex and ever-changing healthcare environment."[66]

In the development of this leadership course an advisory panel of expert nurses with education to the level of MSN or PhD was used to provide information on healthcare trends, curriculum development, leadership and management competencies, and clinical practice internship opportunities. The Task Force developed the core competencies and objectives. Leadership theories were taught using historical and current literature in nursing and other fields.[67] The course also included a group study project with the development of a case study, and analysis of the study. Other content focus was on self-assessment, mentorship and group work with the opportunity to learn from each other, exploring each other's leadership strengths and weaknesses.[68] Some of the content of the course was adapted from Heifetz's theory of leadership, as mentioned earlier in this chapter. The goal of this course is to prepare nurses for front-line management positions as well as other leadership roles in nursing. Using innovative education is a key to developing adaptive nurse leaders.

Military Leaders in the Army have similar views on educating leaders to prepare them for the ever changing operational environment. COL Jon Moilanen and LTC Donald Craig wrote an article in the Military Review (2000) discussing the need for increased leader development to prepare officers for full spectrum operations. Moilanen and Craig examined the need for agile adaptive leaders to enhance the capabilities of military technological systems. They emphasized the combined arms training strategy (CATS) which is a digital program used to educate leaders by implementing vignettes with constantly changing variables such as weather, capabilities, geography and even civilian and political considerations.[69] In the healthcare arena, education tools are available to teach nurses how to assess and provide timely treatment, especially trauma care to patients. At Camp Bullis, Texas, for example, a scenario is given to a team of healthcare providers in the middle of the night with a computerized mannequin with constantly changing variables to include vital signs, bleeding, and even external variables such as notional gunfire. This is very realistic training for trauma care and provides an opportunity for nurses to take the lead role; however, it does not cover leadership in a changing operational environment or political decision-making. It does not provide education for senior level nurses to be adaptive in the joint or multinational environments or to make decisions in other non-patient care arenas.

COL Chuck Callahan and LTC Mark Thompson recognized the need for early AMEDD leadership development. They described the AMEDD leadership education approach as "piecemeal" and emphasized the importance of a formal, concise and quality leadership education program.[70] Callahan and Thompson pointed out the diverse environments AMEDD leaders work in. AMEDD personnel transfer from garrison to

forward deployed environments often with a different set of staff that also have different experiences. They may also be sent to work in a joint service or multinational environment without prior experience or knowledge of either entity. This occurs because AMEDD personnel hold positions in the professional officer filler information system (PROFIS) and will be selected to augment other deployed units to fulfill an empty staff position.

Callahan and Thompson recommended one approach to leadership development that was successful at Tripler Army Medical in 2003 which was called, *Leadership@Lunch*. This program consisted of formal education weekly as a brown bag lunch event concentrating on leadership by using case study scenarios, formal teaching from Army Doctrine and other leadership theorists in an open discussion format.[71] A lunchtime program with a formal dedicated training schedule is an inexpensive and easy to organize option for beginning a leadership program that would benefit all military healthcare professionals.

Another program recommended by Callahan and Thompson was adapted from a program used by major U.S. corporations to develop future chief executive officers. They recommended a four step program which incorporated the *Leadership@Lunch* program by having senior leaders host the lunches and provide the weekly training for junior medical officers. Secondly, senior leaders would identify superstar captains and majors. These particular officers would be the focus for grooming for senior executive leadership positions by guiding their assignments to provide the most well rounded education and experiences. Third, AMEDD would establish a formal mentoring program for all junior officers ensuring the right fit for the mentorship team. Lastly, by the time

the officer reaches field grade level then the time is right for the officer to choose a specific career path whether it be to stay clinically focused, teaching, administration or research.[72] Callahan and Thompson's article presented some insightful ideas for developing adaptive leaders, as medical corps officers, their focus was directed to physician education but could be implemented for nursing education, as well.

This chapter's goal was to review literature that related to the primary and secondary research questions in this thesis. The primary research question is: How can the Army Nurse Corps develop adaptive nurse leaders to be the most effective in the current and future operational environments? First, a historical summary of past leadership roles in the Army Nurse Corps was presented with the changes and challenges nurses overcame to expand their role as leaders in the Army Medical Department. Each of the secondary questions was highlighted with viewpoints from various researchers and authors presented. Ideas for promoting the right leadership education and experiences to assist with developing adaptive nurse leaders were discussed. The following chapters will add to the information gained in this literature review by using qualitative methodology to determine the current and future of adaptive leadership in the ANC. The status of the ANC today will be presented with an introduction of 15 interviews from senior ANC leaders and an analysis of themes found in this research. Finally, an analysis of this thesis will be given and recommendations will be suggested on avenues of approach and additional research needed.

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CHAPTER 3

RESEARCH METHODOLOGY

The role and position of Senior Army Nurse Corps (ANC) leaders has expanded tremendously with many ANC officers assuming command positions such as Hospital Commander and other Medical Commands including The Surgeon General of the Army. Nurses are also leading the medical mission in an assortment of deployed leadership positions. Nurses are receiving unconventional assignments such as Joint Operational Planning, Recruiting, Inspector General and Executive Officer which enhance their opportunities and competitiveness for promotion to General Officer. One primary skill needed to be successful in these and other areas of leadership is adaptability. The purpose of this thesis is to investigate the ANC lifecycle model and determine what changes, if any, need to be made to "build the bench"[1] with future adaptive senior nurse leaders. This chapter is organized first with an explanation of the steps taken to obtain information necessary to address the primary and secondary questions; second, the methodology, sampling, and criteria development are discussed; procedures for establishing validity and reliability of the interview questionnaire will be discussed; and, finally, approval for thesis and interventions taken to protect the human subjects will be explained.

Data Collection Methods

This project required two forms of data collection; objective and subjective. Objective data was collected from an in-depth review of current literature which was conducted using online resources, Center for Army Lessons Learned, Combined Arms

Research Library, at Fort Leavenworth, KS and Stimson Library at the AMEDD Center and School at Fort Sam Houston, Texas. The focus of the collected literature information was centered on recent real-world scenarios to determine what characteristics an adaptive leader must possess. Objective data was also collected in the compilation of demographic information received from the nurses interviewed. Subjective data was collected from a series of interviews. The information collected in these interviews provided an in-depth and informative data bank for the author to utilize in her analysis.

The primary question this study intends to answer is: How can the Army Nurse Corps develop adaptive nurse leaders to be most effective in the current and future operational environments? This is a descriptive study using cognitive interviews. A descriptive survey design is the study of known variables of a specific unstudied population.[2] In this thesis the variable is developing adaptive leaders and the population studied is senior ANC officers. The researcher used structured interviews as the method of collecting data from the focus population. The purpose of the interviews was to explore Army Nurse Corps senior leader's thoughts and expertise to find common themes on what specific aspects of education and developmental experiences need to be incorporated into the ANC lifecycle model in order to develop future ANC Officers to become adaptive senior leaders.

Criteria and Sampling

Consulting with ANC Branch and ANC leadership at the Army Medical Command, Colonels, and Lieutenant Colonels were contacted by email to request for volunteers for telephonic, video teleconference and face to face interviews. Currently there are 140 colonels and 380 lieutenant colonels in the ANC.[3] Purposive sampling was

used to select 15 subjects who were all field grade officers promotable to lieutenant colonel and above in the ANC. Selection of participants was focused on leaders with a variety of experiences, including but not limited to, command, deployments, recruiting, and joint operational assignments.

Appendix A contains the interview questionnaire. It was created with questions intended to promote theme development. The primary and secondary research questions formed the outline of the questionnaire. Thought provoking open ended questions were developed to ensure well thought out detailed answers. The goal was to develop questions that covered areas related to leadership, specifically adaptive leadership.

Validity and Reliability

Procedures for establishing validity and reliability of a study are extremely important. Validity and reliability are important to eliminate error and to ensure the results will be relevant to the questions asked. Validity is a control factor commonly referred to in two forms, external and internal. External validity ensures that the results of the study can be generalized to a larger population. External validity is represented not by random sampling but purposive sampling of a small group. Internal validity refers to the purity of the design so it is used to determine how accurate or truthful the results are. Internal validity is not possible in this study because there is neither experimental design nor control of the subjects. The intent was to ensure variety of experience and education of the subjects in the sample. Face validity is looking at how a variable is measured when a tool is used for the first time. It basically establishes that the tool is likely to lead the researcher into finding the information sought after because the right questions are asked.[4] Content validity was ensured in chapter 2 with the literature review. Face and

content validity of the data collection instrument was ascertained by using three experts to evaluate the tool through a pilot study.

Reliability refers to the systematic way of collecting the data. It measures the consistency and repeatability of the tool.[5] Internal reliability is necessary in qualitative surveys to prevent from branching off the subject out of the focus area. Internal reliability was assured by building the questions on each other and several of the questions repeat parts of the same theme to determine whether the subjects answer with similar type of information.

The interview was tested by piloting it with three ANC senior officers. These three ANC officers are experts in nursing and leaders in the Corps. The evaluators consisted of one retired Brigadier General ANC Corps Chief and two Lieutenant Colonels. The piloting tool is presented in Appendix B. Two of the evaluators reviewed the consent form and questionnaire autonomously. The final evaluator was provided the informed consent form and interviewed in the same manner with the same questionnaire used in the official study. After the interview the evaluators were asked to answer a series of questions that tested the validity of the questionnaire. Piloting the questionnaire was important to ensure validity of the questions as they pertain to the secondary research questions and ultimately the ability to provide a conclusion to the primary research question. The thesis prospectus, methodology, and questionnaire were reviewed by the Command and General Staff College's Director of Graduate Degree Program, the Quality Assurance Human Rights Administer, and the Masters of Military Arts and Science Committee members. A control number of CGSC-QAO-SCN#09-028 was assigned to this thesis by the Human Rights Administer.

Demographic data was collected on each subject to describe the sample and to compare it to the broader population including education and experiences that subjects may have shared and to also capture those officers with unusual assignments and education. The demographic form, at Appendix C, was intended to assist the researcher in describing the sample population. It can show possible similarities of experiences that possibly result into common viewpoints. It will also display the variety of experiences which may represent the diversity of the ANC. Another purpose for collecting demographic data was to determine reliability in ensuring the results of the study may be generalized to the ANC population and benchmark against the general nursing population.

Protection of Human Subjects

All surveys and questionnaires were reviewed and approved by the CGSC quality assurance office, Fort Leavenworth, Kansas.[6] The application packet consisted of the pilot questions, interview questionnaire, consent forms, and thesis prospectus. The ethical standards contained in the Belmont report regarding research involving human subjects were followed by CGSC and the author. The Belmont report outlines the basic ethical principles identified by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral research[7].

The interviews were strictly voluntary. An informed consent form at Appendix D was provided to each subject prior to the interview. The informed consent served the purpose to articulate the reason for the thesis and inform subjects of the type of information desired. The informed consent also served to inform the subjects how their privacy would be protected and how the information they provide will be utilized. All

subjects were offered a copy of their interview and instructed on their right to decline or withdraw from the interview at any time. Finally, each subject was informed of who will receive the collected information with additional confirmation that all identities will be kept in strict confidence. All subjects were informed that the purpose of the interview was to seek out their knowledge and expertise in answering the primary research question: How can the Army Nurse Corps develop adaptive nurse leaders who will be prepared for current and future operational environments?

Summary

This chapter described the methods for conducting this study. The two methods for collecting data were explained. Criteria for selecting subjects for this study were discussed along with the rationale for choosing this particular sampling. Validity and reliability procedures were discussed in detail along with the rationale for ensuring validity and reliability in this thesis. Lastly, interventions for protecting the subjects being sampled were outlined.

Using this descriptive data, chapter 4 will provide a gap analysis between the leadership capabilities and competencies of ANC officers today and what education and experiences are needed to be incorporated into the ANC lifecycle model to ensure the development of adaptive nurse leaders of the future. Recommendations will be provided of possible developmental pathways that may be incorporated into the ANC lifecycle model to equip nurses with the tools needed to become adaptive leaders.

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[1]Horoho.

[2]Pamela Brink, and Marilynn J. Wood, "The Research Design: Blueprint for Action," in *Basic Steps in Planning Nursing Research: From Question to Proposal*, ed. Penny M. Glynn, 5th ed. (Sudbury, MA: Jones and Bartlett Publishers, 2001), 99-113.

[3]COL Susan Williams, Telephonic interview by author, 13 February 2009.

[4]Brink and Wood, *Basic Steps in Planning Nursing Research: From Question to Proposal*, 178.

[5]Ibid., 184.

[6]U.S. Army Command, and General Staff College, "Research Standards," *Student Text 20-10: Masters of Military Art and Science Research and Thesis*, AY09-01 (Fort Leavenworth, KS: Command and General Staff College, 2008), 28.

[7]National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, "Ethical Principles and Guidelines for the Protection of Human," April 18, 1979, Department of Health and Human Services, http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.htm (accessed April 13, 2009).

CHAPTER 4

ANALYSIS

The purpose of this chapter is to provide a gap analysis between the capabilities and competencies that comprise the ANC senior leadership today and what education and experiences are needed to continue the development of adaptive nurse leaders for the future in the ANC. This chapter is organized by first introducing the sample population and providing information regarding the variety of military and civilian education and experiences comprised in the sample population. Next, the pilot study will be described and explained to demonstrate the interview tool development and testing for validity. The data will then be presented with the analytic hierarchy method by presenting data using the interview questions to present themes.[1] A content analysis was conducted and will be presented highlighting common and unique themes found in the sample population's responses. The author's interpretation of these results will be offered in the final chapter.

Sample Population

The sample population for this study consisted of 15 field grade ANC officers from lieutenant colonel to colonel with one major who was selected for promotion to lieutenant colonel. The length of active duty service ranged from 16 years to 32 years of service with the mean years of service being 22 years. Tables 1 and 2 represent sample population size. The mode rank represented is colonel. The mean years of active duty service in the sample population is 22.

Table 1. Sample of 15 ANC officers

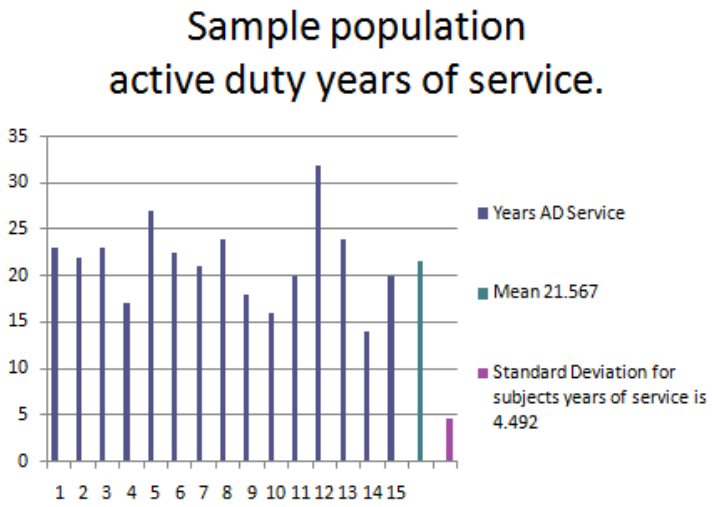


Table 2. Mode rank of sample and mean years active service

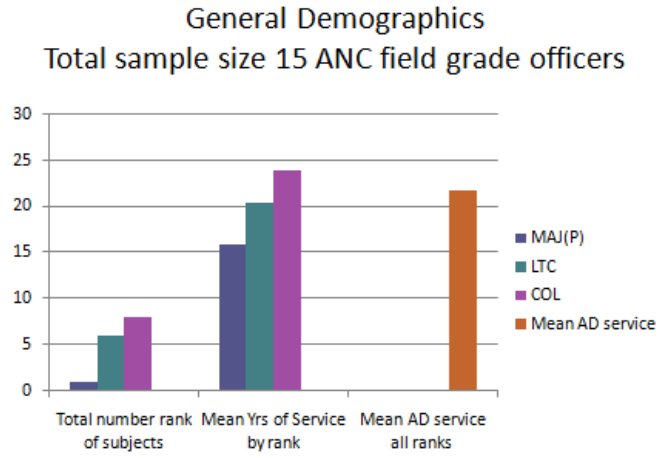
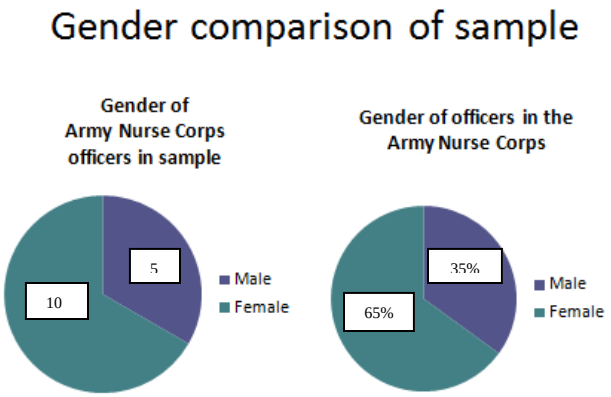


Table 3. Gender comparison of sample



Of the 15 nurses interviewed five were male and 10 were female. This sample correlates closely with the overall demographics of the nurse corps. As of August 2008 in the ANC branch presentation 65 percent of Army nurses are female and 35 percent are male.[2] All nurses held at least one masters degree. Two nurses were near completion of a doctorate level degree and one held a doctorate degree. Nine of the nurses had experience working in a joint environment. Because some joint assignments are not officially titled joint, for the purpose of this thesis, a joint assignment is an assignment which fulfills the doctrinal definition. A joint assignment is any operation, mission, or activity "in which elements of two or more military departments participate."[3] This means that any military member that supervises, works for or works with another military member of a service other than their own is working in a joint environment. Table 3 displays the general demographics discussed and the specialties in nursing represented in the sample of nurses interviewed.

Table 4. General demographics and specialties in nursing

Demographics of ANC sample for MMAS project.

General demographics	
Mode rank	colonel
Gender – male female	5 10
Mean years of active duty service	21.57
Masters degree Doctorate	15 1
Joint service experience	9

Specialties in nursing	
Medical Surgical	7
Intensive Care	3
Emergency	2
Nurse Anesthesia	2
Family Nurse Practitioner	1
Pediatric Nurse Practitioner	1
Adult Public Health	1
Health Care Administration	1

3 nurses with two specialties

All nurses received a demographics form to complete prior to their interview. Five of the fifteen nurse returned curriculum vitaes in addition to or in place of the demographics form. It is from this information in addition to questions five and six of the interview form that information concerning deployment, joint assignments, civilian and military education and experience was obtained. Due to the increased operational tempo the Army is experiencing, Army nurses are deploying more frequently than ever. As shown in Table 4 below, 12 of the 15 nurses interviewed (80 percent) have deployed at least once to a theater outside of the United States.

Table 5. Deployment experience in sample population

Deployment experience represented

Vietnam	1	Bosnia	3
Saudi Arabia	6	Kosovo	1
Kuwait*	2	Iraq	2
Honduras*	1	Afghanistan	1
Lebanon*	1	Pakistan*	1
Hungry	2	Angola	1
Ukraine	1	No Deployment	3

*Deployments less than 6 months.
Some locations represent multiple deployments from individual officers.

Military education is prevalent in the Army and Army Medical Department. Table 5 illustrates some of the many opportunities ANC officers have for educational development. All officers attend a form of Officer Basic Course and Officer Advanced Course also known as the Captains Career Course. Once a nurse has been selected for captain or for a head nurse position he or she may attend a head nurse course which is a two week didactic course introducing nurses to tools required to run a ward or unit.

Table 6. Military education represented in sample

Military Education

Officer Basic Course	15	Joint Operations Medical Managers Course	2
Officer Advanced Course	15	Inspector General Course	1
Head Nurse Course	15	Army Trauma Training Center, Instructor training	1
Combined Arm Services Staff School	5	Field Grade Leadership Development Course	1
AMEDD Company Grade Pre-command	1	Intermediate Level Education/CGSC 16 weeks, correspondent or reserves	9
Combat Casualty Care Course	4	Command and General Staff College (resident) 11mos	6
Interagency Assistant to Federal Healthcare Executives Healthcare Executive Leadership Course	2	Military Health System Capstone	1
Defense Strategy Course	3	Advanced Nurse Leadership Course	3
Faculty Development Course	2	Army War College non-resident	2
U.S. Army Health Facility Planning agency Professional Development Short Course	1	Army War College (resident)	2

Finally, the nurses were asked what leadership positions they have held in the past for one or more years. All of the nurses have held multiple leadership or command positions. Table 6 below displays the variety and plentiful leadership experiences represented in this sample.

Table 7. Leadership positions

Leadership Positions Represented

Command

Deputy Commander Nursing (DCN) CSH	2
DCN MEDCEN	0
DCN MEDDAC	3
Commander (CDR) Clinic	1
CDR CSH	0
CDR MEDDAC	2
CDR MEDCEN	0
Commandant School	1

Non-Command and Branch Immaterial Leadership Positions

Head Nurse	15	Chief Nurse MEDDAC/community hospital or health center	3
Section Supervisor	4	Chief Nurse Medical Center	0
Department Chief	5	Battle Captain	1
Clinic OIC	4	Chief Training Center	2
Division Chief	3	Clinical Director	2
Assistant Chief Nurse	3	MEDCOM staff officer	3
Chief Nurse Combat Support Hospital	2	OTSG staff officer	2
Senior Clinical Instructor	6	ANC Branch	1
Evening Night Supervisor	2	MEDCOME Inspector General	1
Recruiting/ROTC	6	Congressional Intern	1
Executive Asst. to Chief ANC	1	Consultant to OTSG	4

Pilot Study

The pilot study involved designing a series of questions for the interview using the secondary research questions. First the interview tool was evaluated by the MMAS committee, Philip Wyssling, logistics instructor and committee chair at CGSC, and Kevin Gentzler, leadership instructor at CGSC. The final review was conducted by the author's Nurse Advisor and Adjunct CGSC faculty, COL Bruce Schoneboom, AN, CRNA, Ph.D. who is also the Uniformed Services University of Health Sciences, Associate Professor with the Graduate School of Nursing and Associate Dean of Academic Affairs.

The three experts, (Bester, Toven, and Prior) as mentioned in chapter 2, reviewed the interview tool evaluating it for consistency, time, relevancy and validity. The questionnaire was sent to the first two experts to conduct a mock interview and examine the tool individually. Guidance received from the first two experts consisted of the need

to shorten the interview, clarification of questions and prioritizing the individual questions to flow consistently. The last expert received the interview from the researcher telephonically in the exact manner the interview would be conducted to the actual sample. The interview took 45 minutes which closely matched the estimated time. At the conclusion of the interview the expert provided insight and guidance about qualitative research and interviewing techniques. The tool was approved by the final pilot expert and submitted to the Quality Assurance Humans Rights Administer for approval prior to conducting the first official interview.

Interview Results

The interview results reveal several common themes in all areas. Refer to Table 7 Interview Results on the next page. The results table directly outlines the interview questionnaire and reflects the exact responses from the participants. The table is constructed beginning with the interview questions in the exact order asked during the interview. Themes that were brought forward during the interview are noted in the center of the table. Finally, comments made by participants are listed. Selection of comments to highlight were made by focusing on the most specific answers and also based on the subjective analysis of emotional response tied to questions asked. Some participants were extremely vivid in their responses and it was immensely clear that the topic at hand was very important to them. Not all responses are represented in table, however, all responses were considered during the analysis of this study.

Table 8. Interview Results

Interview Questions	*Themes*	*Statements from officers interviewed.*
When I say leadership in nursing or "Nurse Leader" what comes to your mind?	Head nurse, chief nurse, clinical expert, leader of soldiers, teach, coach mentor.	*Strong clinically, tactically(1,2,5,7,14) *Can lead soldiers, civilians, and the practice of nursing.(13) *Every Army nurse is a leader..must take opportunities to lead.(8) *Comprises whole spectrum coach, teacher, mentor(9)
If you were selecting individuals for promotion, what would you be looking for?	Variety of experience, education, hard jobs, clinical competence, stamina, physical fitness, well rounded, deployment	*Ability to do their job and do it well. (11) *What has this person done…contributions..surroundings,. unit..nurse corps..educ..research..(6) *If a person hasn't deployed…why(2)
What do you see as your strong leadership attributes?	Caring , business	*taking care of…..(1,2,5,11) *ability to look strategically(13) *strong business sense, I am data driven(2) * having long and short-term goals(14)
What areas of your leadership skills do you feel you could improve upon?	Patience, mentoring	*Like to see results very quickly and not everyone shares that same sense of urgency(13) *taking care of…(3,10,) *I focus on mission, more personal(9)
Held a joint position or worked in a joint environment. If yes, please elaborate what your responsibilities were and how did these experiences affect or change you?	Yes, refer to table 4 No real theme –all unique	*Refer to table 4 * Taught me to be more adaptive (14) *Taught me what was important in life.(3,13) *Gained a new set of skills and learned to work with other services and branches.(1,2,4,8,13)
What kind of formal education/training or experiences did you have	Most common first response was "on the job" mentoring either	*Biggest experience was mentoring (6) *Trial by fire!(7)

that prepared you to be a leader? A. Formal, B. Mentoring, C On the job.	very good or non-existent.	*I was going to get out…he took time…mentor..still reaches out.(3) *It is rare to find a true mentor.(2)
A. Formal	Graduate school, military education.	*HN course didn't go into the basic things (2) *Lots of formal civilian education...ROTC(13) *CGSC correspondence not very useful.(12) *Higher education gives me the knowledge base.(10) *Masters degree most helpful.(1,5,9,13)
B. Mentoring	Coach not mentor, mentoring – divided theme	*Education gives you formalized tools to use as a leader but not how to handle daily issues. Mentoring does this.(6) *Most nurse leaders are coaches not mentors.(2,7,11,)
C. On the Job	Experiences	*Working right away on nights/charge taught me a ton.(7) *Having real challenges tested my ability to be a leader.(14)
Can you give one example when you had to influence, motivate, and provide direction while operating in a complex and uncertain environment to accomplish your mission? Explain.	All participants said YES. Deployment with inexperienced nurses, HN	*Brand new LTs with very limited ICU experience on deployment setting up hospital with very little sleep.(14) *Poorly defined dangerous mission..had to educate and motivate people who spoke another language.(3) *Battle captain on deployment.(4)
If yes, did you successfully overcome this challenge? How?	All participants said YES	*Take the time to teach, motivate, provide direction.(14) *I had to quarterback, motivate, it was a good team.(3)
Do you feel you were adequately prepared for	YES – 7 Experiences -5	*I have been around - challenges keep me learning.(14)

the experiences discussed in the last 3 questions? Explain	Mentorship - 2 NO – 6 YES and NO - 2	*You can't be 100% prepared…you get through it.(6) *Years of practical experience…right away Army nurses are asked to step up to the plate, different then civilian.(7) *I don't know if I can say I have ever been adequately prepared.(2) *No education, preceptorship or structured mentorship before I went to those jobs.(4) *There were political parts that I had to learn that was difficult.(12)
What does the term "adaptive leader" mean to you?	Flexible, open-minded, able to change leadership style	*Role with the punches.(12,15) *They can change to accomplish the mission.(4) *Someone who can vary their leadership style based on their situational analysis.(2) *Someone that can go from tuxedo to acu's….they can work all avenues field or garrison.(3) *Someone who cannot decompensate when the conditions change. Instead they are able to take this information that is presented and seemingly integrate that into the decision making progress. **Leaders need to be able to step outside the box, listen to others, transform yourself into a variety of ways to accomplish the mission.(14)
In what ways do you think nurses need to be adaptive?	Flexibility, deployed environment. Leadership style	*ANC officers need to be able to adapt to the changing environment, especially on deployment ..allow for flexibility.(14) *Nurses need to remember that they are soldiers too and they need to adapt to the changing conditions in the Army.(13)

		*We are constantly changing; our environment and circumstances are consistently changed so you have to be a change agent.(9) *Some nurses forget where they came from and that at one time they were a young nurse who was still learning and making mistakes.(10). *you have to keep learning things that are outside of nursing…educating yourself on the big picture.(15) We have to train them to be adaptive.(12)
Do you consider yourself to be an adaptive leader? Explain	Yes -13 Sometimes – 1 Don't know - 1	* Challenges I have faced allowed me to become an adaptive leader.(14) *I use contingency leadership style when I break away from transformational. I try to be a change agent.(3) *Most of the time, I think I am. I am clinically oriented, listening to subordinates and what they think, take that energy and work with it.(1) *I can adjust to the situation.(8) *I hope I am, I think I am. I don't think you'll succeed if you're not.(15) *I embrace change. Sometimes it enthralls me, drive, competitive edge..Exciting.(6).
What do you see as the primary strengths of the ANC senior leaders?	Strength, educated, experienced, versatility, diversity	*Diversity of population and assignments. Challenges you never ask for but are given.(15) *Homegrown – familiar with the organization..different from civilians who get hired into leadership jobs.(6) *We have the ability to do a lot across the continuum…I think that is why nurses do well in command.(1) *Versatility, experienced, protect the practice of nursing from encroachment. Our strengths are our diversity…well educated..articulate..loyal and reliable(13) *Versatility, knowledge, motivation and great ideas.(5)

		*We are a highly educated and experienced group.(9) *I see them as strong leaders, are adaptive to what the changing needs are, definitely experienced.(10)
What areas of improvement do you see are needed in the area of leadership in the ANC?	Jr. leader development, Mentorship Head Nurse development	*We don't have formal leadership training for our LTs(8) *We push…away from med/surg..need to bring back the glamour of being an Army nurse. The nurse internship is a great idea, keep it. Stop saying mentor and start saying coach(2,3,14) *We don't do enough mentorship. Too many taskers for HNs, HNs are out doing so many projects that mentorship gets lost.(12) *HN are our weak area..HN poor leaders – not everyone is meant to be a HN. We need to be more selective of HNs ..it's the toughest job but most important.(5) *There is a gap between our senior leaders and our young. So many roles for nurses and not all with a mentor path.(13) *Senior leaders need to listen, really listen to our young officers and also to our MAJs and LTCs.(4) *Better education for leadership and command.(15)
If you were able to add, remove, or change milestones in the ANC lifecycle model, what modifications would you make, if any?	1.Two paths: Clinical and leadership/admin 2. AOC later 3. HN education earlier and better.	*Focus on Jr. leaders, provide more leadership education..give them the tools, be role model to them.(14) *Looks like we value other things more than clinical(9) *The mentality is you can't stay in clinical arena, you need to go out and be a chief nurse, staff position or whatever…Advanced practice nurses need to know they can be successful without doing other things.(5) *It would be good to have a life cycle model for each AOC.(7) *Identify 2 paths and let clinicians stay

		clinicians. (3) *Different tracks based on your AOC. If you want to be an administrator you would be taken out of the other track.(6) *Slide AOC specialty course to right start after 2yrs. We don't really say where the staff nurse falls under clinical. The bedside is our key role and it isn't really represented here.(2) *I wouldn't push LTs to go to an AOC course so fast and even expand it to 8 yrs so they don't have pressure to choose. Add some leadership training. Start research earlier ..even staff investigation.(8) *Move AOC to right, 2LTs should not be going to specialty courses. They need 2 yrs to improve their skills.(12) *Get to HN course earlier before they slide into a HN job.(14) *We need to ensure our nurses get HN experience and get mentored as HNs.(13) *Keep LTs in Med/surg longer…need not rush folks into the specialty courses.(1,2) *Ensure we aren't taking CPTs away from bedside too soon.(11)
What additional opportunities do Army nurses need to become adaptive leaders?	Military training	*I always get excited when I see nurses go to non-traditional assignments like command or CGSC in-residence at Ft. Leavenworth etc.(14) *Spectrum training or Meyer's Briggs.. you need to understand yourself before you can understand others and how to work with them.(2) *Experience for officers …like doing a job with the line units so you can better understand how they do things and better work with them.(8) *Training on how to be better leaders and mentors.(10) *Operations would be one job that would be good to get nurses experience as they get senior.(1)

	*Formally teach us leadership skills, working with people, group dynamics, anger management, handling all the paperwork, emails etc to get the job done…(15) *Just an additional military training course(5) *We need more TOE and field experience. All nurses should be deployed at one time in their career to get experience with the line guys. We just see the medical part and that is not the Army.(4)

An important finding developed creating a theme contrast between nurses who have deployed versus those who did not. The 12 nurses that have deployed all mentioned the importance of soldier skills and developing a relationship with the operational officers. They mentioned various avenues to do this such as deployment, CGSC or other military education with line officers, or staff positions. The nurses without deployment experience did not mention military education or deployment. The focus for these participants was toward technical skills and clinically focused.

Another point to highlight from Table 8. was the response that participants gave when asked if they felt they were prepared for the positions they had during joint and deployment assignments. Six out of the fifteen participants said “no” they were not prepared to lead in their respective positions. Two of the participants stated that they were prepared for some assignments and others they learned on the job. The other seven participants explained that experiences from the past in nursing, graduate school and past assignments gave them the tools they needed to figure out how to do the challenging missions.

Some unique views surfaced in the interviews by those who have held command positions and other un-conventional positions. Below is a quote taken from one participant's interview.

> I feel as though I have been well prepared to take information that has been presented to me and to integrate it into the decision making process of my organization. One of the measures for success senior leaders in today's military are to strategically see 2nd and 3rd order effects in changing situations. So while I could handle an emergency today at the hospital, I am constantly thinking 2-5 years ahead so the decision affects the future.

One participant stated that head nurses are far removed from the lieutenants. The participant stated that lieutenant colonels should not be head nurses of lieutenants without a captain or major being present for the lieutenants to relate to. The participant felt that lieutenant colonels are too far removed in rank from the staff. This is part of the problem with mentorship or lack of mentorship. Noteworthy, one participant stressed adaptiveness as an area needing improvement. Another did not understand the term adaptive leadership.

Two participants gave truly unique views of characteristics they believed were important for promotion. The first participant said "Balance their work life with home life." The second participant said, "They should take time to fulfill their own happiness. It is pretty evident when you see their CV whether they have balance in their life." They both said it gives the officer credibility. This is an interesting point because Army doctrine refers to balance as an emotional trait that contributes to leader intelligence. Doctrine states that balanced leaders greatly influence their ability to interact with others, to make the right decision and be decisive, and to provide their staff with the right perspective.[4] In referring to adaptive leadership, it is important to quote this passage from FM 6-22, "Balanced leaders know how to convey that things are urgent without

throwing the entire organization into chaos."[5] Balance is also a frequently spoken term by senior leaders at CGSC when referring to developing majors to be senior leaders in the Army. Characteristics in the definition of a balanced leader can also be found in definitions of an adaptive leader. So, it can be concluded that balance is a characteristic to be developed in ANC officers to promote adaptability.

In the area of education, all had positive comments on the civilian education opportunities. Three participants stated a need for more training with industry to learn how things are done in the civilian sector but also because it is likely to foster a sense of appreciation for how things are done in the AMEDD. Participants that had attended CGSC or Army War College in residence made a note to mention the value of that military education and networking with line officers. The participants that did not attend any field grade developmental school in residence either did not mention the correspondence or reserve course attended or made a negative comment about the worthiness of the non-resident courses.

Thirteen participants voiced the need for further education and experience to develop adaptive nurses. While discussing the life cycle model a strong theme of the need to keep nurses at the bedside longer working on medical surgical wards surfaced. These nurses stated that LTs were being taken from the wards much too soon and sent to specialty courses. The theme was strong that nurses are being pressured into selecting a specialty instead of allowing the time and experience to bring the interest forward. The last incredibly strong theme was the need for the life cycle model to be split into two tracks, clinical and administrative. The participants stated that nurses who want to stay clinical should be allowed to do so without repercussion of not getting promoted as

quickly as the administrative nurses or command nurses. The view was that the ANC is losing clinical expertise by forcing nurses to do both.

This purpose of this chapter was to explain in detail the methodology used in this project and the process in obtaining the data collected. This chapter also presented the results of the data collected and identified common and unique themes which surfaced during the 15 interviews conducted. Chapter 5 will present the authors conclusions to the analysis and recommendations both on course of actions to ensure the development of future adaptive nurse leaders and recommendations of further research.

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[1]Jane Ritchie, Liz Spencer, and William O'Connor, "Carrying Out Qualitative Analysis," in *Qualitative Research Practice: A Guide for Social Science Students and Researchers*, ed. Jane Ritchie and Jane Lewis (Thousand Oaks, CA: SAGE publications, 2003), 219-61.

[2]COL Susan Williams, "2009 Branch Brief," January, 2009, U.S. Army Human Resources Command, http://www.hrc.army.mil/site/protect/Active/ophsdan/default.htm (accessed February, 2009).

[3]Headquarters Department of the Army, Joint Publication 1 (Washington D. C.: Government Printing Office, 2007), I-2.

[4]Headquarters Department of the Army, FM 6-22, 6-4.

[5]Ibid.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this thesis was to investigate how ANC officers are currently being developed to become adaptive leaders who will continue to mature as effective senior nurses and leaders of the ANC, the Army Medical Department and the Army. In achieving this goal the intent was to study the ANC life cycle model by comparing the development pathways to other branches of the Army and exploring current civilian and military theories for developing adaptive leaders. Army doctrine was also reviewed to discover the military official view on the definition of adaptive leadership, how the Army develops adaptive leaders and to investigate how the Army can meet the needs of the ANC in building adaptive nurse leaders.

Summarizing the findings from this study and providing a clear interpretation of the results is the intent of this chapter. Recommendations to the ANC will also be given from the author's viewpoint of what education and development could prove useful to sustain or improve in the development of adaptive ANC officers. Suggestions for further research will also be recommended in the conclusion of this chapter.

Interpretation of Findings

Themes revealed during the interviews that centered on education and development focused on extending the time a junior officer remains as a medical surgical staff nurse, increasing military education specifically tailored to leadership, and improvement of existing courses such as the head nurse leadership course. The need to provide more training together with the other branches of the Army to specifically

include units such as brigade combat teams was discussed. Several participants who had attended service schools in residence such as the Command and General Staff College, the Army War College and the Pre-command Course felt that added opportunity for select ANC officers would improve the relationship between the ANC and the operational branches. Additional military education would also develop more ANC officers to be prepared to take on the senior leadership roles such as hospital command, chief nurse, and staff officer to The Surgeon General.

Also the majority of senior officers felt that the ANC life cycle model should have two clearly defined developmental tracks. Clinical and administrative tracts are the two pathways most commonly stated. They expressed views that promotion and assignment boards should be educated on these pathways to improve the representation of clinical specialist as well as administrative leaders. Strong opinions were represented that nurses who want to remain clinical specialists such as nurse anesthesia, trauma, nurse practitioner and clinical nurse specialists should be afforded the opportunity to do so. The ANC loses specialists that are greatly needed to provide expert consultation and patient care when they are taken from the clinical arena to hold administrative positions. This also creates disgruntlement among both the clinical nurse who was taken from the ward, clinic, or operating room and the subordinate staff. Additionally, there are nurses that have the talents and desire to become administrative leaders. These nurses thrive on working the budget, planning, leading and managing nursing and running the hospital, unit, or command.

Strong sentiments were expressed that not all nurses had the potential to be good head nurses; however, there are some of these nurses placed in those positions because it

is a key and developmental assignment in the life cycle model. Many nurses do not have the desire to be head nurses in charge of a ward. It is one of the most challenging positions in the ANC and requires excellence in leadership, time management, budget management skills, complex multitasking, and adaptability. Nurses without head nurse experience are at a disadvantage at promotion boards. Placing unqualified people in head nurse positions may cause hardships to subordinate staff. This could result in a domino effect of the unit not running as smoothly and efficiently as it could. This is an area that requires further investigation and consideration for change.

Areas to sustain were also noted in the interviews. The majority of senior nurses favored the officer basic and the captain's career courses. One officer felt the captains' career course could be longer. The participant said that it used to include everything that the other branches had. Participant did not elaborate specific content missing in the course. All the nurses praised the long term health education and training program noting that much of their leadership education was obtained during their graduate programs. Those that participated in the training with industry program felt strongly that this program should be sustained and offered to more nurses who obtained a masters degree without the assistance of the nurse corps. One major note of sustainment was the nurse residency program. This program provides a valuable orientation to nursing with precepting opportunities at various wards prior to beginning work on a specific unit. It also allows for a baseline evaluation of clinical competency for the junior nurse.

Recommendations

The primary research question is: How can the ANC develop adaptive nurse leaders who will be prepared for current and future operational environments? The focus

of this thesis was to examine the ANC life cycle model and investigating both current and prospective methods for the development of adaptive leaders in the ANC. To begin, the author first examined the first secondary research question: What does the term "adaptive" nurse leader mean? Based on knowledge gained from literature review and interviews conducted the author proposes a definition of adaptive ANC leaders.

> An adaptive ANC leader is one who is a clinical expert and can alter leadership styles to be effective across the horizontal and vertical organizational structures to meet the full spectrum operational mission. The adaptive leader is effective in both garrison and austere deployment environments. The adaptive ANC leader must be knowledgeable in Army and Joint doctrine, must understand the strategic and operational objectives of the Army, and has the ability to view problems holistically and turn ambiguous challenges into opportunities.

Clinical expertise is necessary to allow the ANC officer to think quickly in a time of chaos and needed for self confidence in making a quick decisive decision. Clinical expertise is advantageous for the nurse leader to reach the next level of adaptability. The adaptive ANC leader has the ability to look holistically at any situation, environment, and organization and take any and all challenges in stride turning these challenges into opportunities. The adaptive ANC leader can alter leadership styles to accommodate the horizontal and vertical military and civilian staff personalities and meet the mission. In order to be adaptive as a nurse and Army officer the ANC leader must be knowledgeable in Army and Joint doctrine. The ANC leader must understand the strategic and operational objectives of the Army and Nations leaders and understand how the AMEDD mission fits into the overall plan. The officer must be capable of relating with operational and non-operational leaders and know how and where to find military information outside of nursing. Development of adaptive ANC leaders must begin at the earliest point of their career.

Building adaptive leaders begins with arming junior and mid-level officers with the tools needed clinically and through military assignment experience to be successful in their positions. The findings in this study are directly relevant and extremely important to address in determining how the ANC can improve the life cycle model by improving the education and developmental pathways to be more tailored to the needs of the ANC, the Army and the nurse corps officer. Ensuring ANC officers are armed with the proper tools begins with the life cycle model and its contents.

One suggestion is to increase the number of seats in the Army resident courses to allow for more nurses to attend. The 16 week resident Intermediate Level Education course is one program that could be expanded. The 16 week course curriculum is the same as the resident ILE course. Specialists in both courses teach the material related to their career field. This is different from the reserve course which is taught on a part-time basis with one or two instructors to teach the entire curriculum. Distant learning students do not receive the benefit of the adult active learning group environment. The participants validated the author's analysis by verbalizing positive experiences from those who attended ILE in residence and negative comments from those who obtained their certification through reserves or distance learning. Additionally, the advanced resident courses such as Command and General Staff College 10 month program and Army War College are excellent programs and increasing the number of slots dedicated to the ANC would provide an excellent opportunity for the ANC to prepare nurses who have the potential to become top influential leaders in the corps.

Investigation into the policy and rationale for disqualifying Army nurses from attending SAMS is warranted. SAMS is a program for the best of the best among

operational officers. Not allowing officers of all branches to compete for selection could possibly cause top notch officers to be overlooked. Certainly this course is not for everyone but with the additional branch immaterial positions being held by ANC officers this course could prove to be beneficial to those nurses who could possibly hold one of these positions in the future.

Another recommendation is to develop a method for selecting officers for head nurse positions either at the unit level or brigade level. Nurses should not be placed in a head nurse position if they do not have the aptitude for it. Additionally, competent nurses who do not have the leadership traits needed for a good head nurse should not be penalized for promotion if they possess the clinical skills required of their specialty and choose to remain in the clinical tract.

The author recognizes that nurses in general must be adaptive in daily clinical activities. Nurses are well known for resourcefulness and ingenuity. Nurses are critical thinkers, problem solvers, and able to help patients adapt to their situation and environment. However, full spectrum operations, the current increase in operational tempo, and the steady increase in the senior ANC roles in the Army require unique and additional skills for Army nurses to remain adaptive leaders as they grow in rank and responsibility.

Further investigation into specific current military education programs is warranted to determine if the appropriate type and amount of leadership education is incorporated in these programs and that each program builds on the first. Because of the strong views by all participants regarding the quality of head nurses in the ANC today and the concerns for a need to improve the head nurse leadership course, more research is

needed to specifically focus on the head nurse population and ranks of head nurses captain through lieutenant colonel. An investigation into the curriculum is needed to ensure head nurses receive the proper tools to be successful.

MG Horoho has already initiated imperative action teams (IAT) to conduct research in the focus areas above. During the course of this thesis, the author joined one of the leadership IAT which is chaired by COL Bruce Schoneboom, also the nurse advisor for this thesis. The leadership IAT will be conducting a gap analysis in the area of leadership development for ANC officers. Active duty, reserve, and non commissioned officers in the ANC, as well as, civilian nurses from across the country are working together on this most important project. Additionally, the leadership IAT has a clinical leadership working group that is specifically investigating the education and development for head nurses.

Ensuring junior nurses receive adequate time on the inpatient unit to allow for their clinical skills to be polished is recommended. Popular views of participants in this project indicated concern that many junior nurses do not receive enough medical surgical nursing experience prior to attending specialty courses. The nurse residency program has improved this issue, however, continuous effort to teach, coach, and mentor junior nurses and ensuring they are not transferred from the medical surgical unit too soon is imperative.

One of the most difficult competencies to measure is leadership. The author recommends a more structured counseling tool for developing junior leaders by using core competencies directly noted in the Army Leadership Competency Model seen in Figure 4. The author advises the development of a competency tool that is valid and

reliable that specifically measures leadership competencies both in the area of nursing and general military leadership. An updated tool should be used for each rank and level of responsibility. It is necessary to have a clear measuring tool to ensure adaptive and other leadership skills are able to be evaluated prior to placing ANC officers into the more difficult staff, leadership and command positions. These competencies can be addressed in quarterly counseling and used in a collaborative effort by the chief nurse and assignment branch manager for assignment selection. The intent is for it to be used as a developmental tool and not for punitive purposes. It would allow for closer monitoring of education and experience needs of the individual nurse.

Finally, at the unit level, head nurses, section chiefs, and chief nurses can focus efforts on selecting mentors for new nurses right out of the officer basic course. Having an initial mentor assigned opens the door for new nurses to ask for help and guidance. It provides an opportunity for them to be encouraged to take on new challenges knowing someone will be available to steer them in the right direction. As seen in the literature review and interviews, challenging nurses will teach them to become comfortable with the uncomfortable situation. The more challenges a nurse succeeds at the more knowledge through experience they will acquire. The list below summarizes recommendations which may be helpful in the continuous development of adaptive ANC leaders.

1. Develop focused life cycle models for two tracts, a clinical and a leadership tract.

2. Increase ANC attendance to resident military courses.

3. Groom top performers who are likely to command and reach the highest levels in the AMEDD by allowing them to compete for selection into advanced courses such as SAMS.

4. Develop a process for selecting nurses for head nurse position who have the leadership competencies and characteristics to be successful.

5. Conduct thorough analysis of current developmental education programs to ensure appropriate leadership education is integrated and builds upon previous level.

6. Ensure all new nurses receive medical surgical experience for minimum of one to two years prior to specializing.

7. Incorporate a structured mentorship program into unit's orientation program for junior officers' first assignment.

8. Ensure quarterly developmental counseling is being conducted and is structured based on the leadership competency model. Hold supervisors accountable for the development of subordinate officers.

9. Teach head nurses and section supervisors new and innovative ways to coach, teach, and mentor staff and how to challenge young officers while providing safe environment.

Two areas not considered in this thesis are the method for selecting nurses for leadership positions and the officer evaluation system. The selection board process was not investigated nor was the quality of the officer evaluation report for measuring leadership. Additional research could be conducted in these areas.

The thesis also did not address similarities or differences that gender may have in adaptive leadership characteristics or potential. No participant commented on the

effects gender may have on leadership abilities or opportunities. Cultural, ethnic differences or professional bias was not commented on either. The interview questionnaire did not address these variables. Additional research is recommended to compare the effects gender, cultural or ethnic differences may have on the ability to lead others effectively. Also, the challenges that may occur with each of these variables and how adaptive leaders overcome these challenges is an area of further study.

The participants in this thesis first stated a definition for the term "adaptive leader" and then proceeded to answer whether or not they were adaptive leaders. 13 out of 15 participants viewed themselves as adaptive leaders. A follow on study using the author's proposed definition of adaptive ANC leader would be beneficial to see if the participants would view themselves as adaptive leaders when the definition is given to them. It would also be worthy to use the proposed definition of adaptive ANC leadership and ask how junior officers view their senior leaders. Lastly, it would be beneficial to conduct a similar descriptive study interviewing junior and mid-level officers to discover what their views are about their leadership development.

Conclusion

The ANC life cycle model has been a valuable guide to promoting the development of well-rounded nurses and leaders. In order to continue the advancement of the Army Nurse Corps profession the life cycle model should be frequently examined and updated. The purpose of this thesis was to examine the life cycle model, specifically the leadership education and experience pathways of Army Nurse Corps officers. A literary review of military and civilian theorist on adaptive leadership and an analysis of current senior ANC leaders' perspectives on leader development were conducted. From

this information the author developed a definition of adaptive leadership pertaining specifically to senior ANC officers. Recommendations were made to increase leadership and military education opportunities that could prove valuable in the development of adaptive leaders. Lastly, recommendations for further research was given which may assist ANC officers with meeting MG Horoho's intent to "build the bench"[1] with future adaptive senior nurse leaders.

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[1]Major General Patricia Horoho, "Our Priorities," *The Army Nurse Corps* 8, no. 7 (September 2008): 1, http://www.us.army.mil/suite/portal/index.jsp (accessed 20 September 2008).

APPENDIX A

Interview Questionnaire

Control number of CGSC-QAO-SCN#09-028

1. When I say leadership in nursing or "Nurse Leader" what comes to your mind?

2. If you were selecting individuals for promotion what would you be looking for?

3. What do you see as your strong leadership attributes?

4. What areas of your leadership skills do you feel you could improve upon?

5. Have you deployed?

6. Held a Joint Service position or worked in a joint environment?

    a. If yes, please elaborate what your responsibilities were.

    b. How did these experiences affect or change you?

7. What kind of formal education/training or experiences did you have that prepared you to be a leader? A. formal B. mentoring, C. On the job? Explain:

8. Can you give one example when you were a leader in a unit where you had to influence, motivate and provide direction while operating in a complex and uncertain environment to accomplish your mission? Explain.

    a. If yes, did you successfully overcome this challenge? How?

9. Do you feel you were adequately prepared for the experiences discussed in the last three questions? Explain.

10. What does the term "Adaptive Leader" mean to you?

11. What ways do you think nurses need to be adaptive?

12. Do you consider yourself an adaptive leader? Explain?

13. What education and experience is most important in developing adaptive nurse leaders?

14. What do you see as primary strengths of the ANC senior leaders?

15. What areas of improvement do you see are needed in the area of leadership in the ANC?

16. If you were able to add, remove, or change milestones in the ANC Lifecycle Model what modifications would you make, if any?

17. What additional opportunities do Army nurses need to become developing adaptive leaders?

APPENDIX B

Questionnaire Piloting Tool

How long did it take to complete?

Do any of the questions need to be explained?

Were any questions objectionable?

Were any topics omitted that need to be discussed?

Were any questions unclear or ambiguous?

Were questions relevant to research question?

Do the interview questions build upon the topic?

Are any of the questions leading?

Comments?

APPENDIX C

Demographics Form

1) Rank - _____

2) Specialty - _____

3) Highest Degree – Masters/Ph.D

4) Military Education post AOC/CCC

_____

_____

5) Years in Service – AD_____/ Reserve_____

6) Years in ANC - AD_____/Reserve _____

7) Civilian Nursing Experience – yrs_____

8) Deployment experience yrs/mos _____

9) Deployment location – list all_____

_____

10) List any position other than staff nurse/head nurse you have held for any length of time._____

APPENDIX D

Informed Consent Form

SUBJECT:_____

DATE:_____

Interviewer introduces herself and reads to subject. Interviewer reads to Subject:

"The purpose of today's interview is to explore Army Nurse Corps senior leaderships thoughts and expertise to find common themes on what specific aspect of education and developmental experiences need to be incorporated in the ANC lifecycle model in order to develop future ANC Officers to become adaptive and resilient Senior Leaders. Purposive sampling was used from a database of all Lieutenant Colonels and above in the ANC focusing on leaders with a variety of experiences to include deployments, recruiting, and joint operational assignments."

"Do you understand that today's research interview is voluntary and that you may terminate the interview at any time?"

Write response: Yes or No _____

"May I tape record this interview?"

Write response: Yes or No_____

"Research data will be kept anonymous. Research results will be compiled and analyzed and final thesis will be presented to the Director of Graduate Degree Programs at CGSC, MMAS Committee Chair and Members for thesis defense and ultimately MG Patricia Horoho, ANC Chief and COL Suzie Clark, Assistant ANC Chief to assist in determining possible changes that may be incorporated into the ANC Lifecycle Model."

"At this time, are you ready to answer questions?"

Write response: Yes or No_____

"Would you like to receive a copy of your taped interview?"

Write response: Yes or No_____

SIGNATURE _____

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